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ABSTRACT

This paper reviews the research of the effects of involuntary residential relocation on the personal adjustment of institutionalized individuals, i.e., the institutionalized elderly, mentally ill, and mentally retarded. Discrepant findings in studies of involuntary relocation are discussed in terms of the transferees' personal characteristics, the environmental and process factors of the change, and the varying impacts of relocation on some groups and under certain circumstances. The variability in personal reactions to relocation is explained in terms of stable individual characteristics, cognitive mediators, and environmental characteristics. This review examines relocation from an ecological perspective that accounts for both the subjective and objective features of the old and the new environments. (Author/NRB)

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The Effects of Involuntary Residential Relocation on Institutionalized Populations: A Review

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Residential relocation is one type of life event which requires major social readjustments. When it is imposed on people it can result in considerable stress and concomitant changes in their physical and mental health. Major government urban renewal projects, industrial factory relocations, and job transfers within large companies have necessitated involuntary residential relocation of the inhabitants and employees affected. In recent years institutional populations have undergone widespread relocation as the service system has been in a state of flux due in part to the deinstitutionalization movement. This talk will focus on studies of institutional relocations, which have been investigated mostly among the elderly, but also among the mentally ill and the retarded.

Theories of the effects of involuntary relocation

Theorists have made an explicit comparison between bereavement and the process of social change inherent in involuntary relocations. Fried (1963) describes the nature of the loss in relocation as a disruption in one's relationship to the past, present and future. It brings abount fragmentation of routines, relationship, and expectations. As in reactions to loss of a limb or of a spouse, the symptoms of grief are similar, including feeling of painful loss, continued longing, general depressive tone, frequent symptoms of psychological, social, and somatic distress, sense of helplessness, occasional direct and displaced anger, and tendencies to idealize the lost place. Parkes (1972) describes the grief process as occurring in four stages: a) shock, in which the reality of loss is denied, b) anxiety and distress, the urge to recover those parts of the world which were lost, c) depression and

apathy, and d) reorganization and reduction of feeling, which involves learning new patterns of thought and behavior.

Stress, such as that caused by involuntary relocation, is determined by the personality and motivation of the individual, the belief system concerning transactions with the environment, and the external resources and supports available to him. If the stressful event is highly unfamiliar and unanticipated, it will be perceived as a threat. Reactions to stress depend not only on appraisal of threat, but also on coping strategies for dealing with change. What is a crisis for one may be a moment of opportunity for another. A stressful event may have more drastic consequences for people who are in a more dependent position and have fewer social roles and differentiated behavior patterns to use in coping such as young children, elderly people and retarded individuals (Lazarus, 1966).

Effects of transfers on elderly, mentally ill and mentally retarded residents

Many researchers have reported on the deleterious effects of relocation of institutionalized populations. Among the elderly, a move from one institution to another has often been followed by an increase in mortality. Aldrich & Mendkoff (1963) report a 32% mortality rate within 1 year following relocation as opposed to an expected rate of 19%. Following a fire, Aleksandrowicz (1961) reported 20% mortality rate in 3 months in comparison with 7.5% the previous 3 months. Other deleterious effects include increased level of plasma cortisol (Kral, Grad and Berenson, 1968), pessimism with regard to health outlook (Bourestom and Tars, 1974), decreased psychological activity, and changes

in physical and mental health, self-care, and social capacities of the elderly (Bourestom and Tars, 1974; Kasteler, Gray and Carruth, 1968). On the other hand, a few recent studies (Markson and Cumming, 1975; Miller and Lieberman, 1965; Kowalski, 1978) did not find increases in mortality among the elderly following relocation. However, one of these, Miller and Lieberman, did report declines in psychological functioning in 23 of the 45 people moved.

A "relocation syndrome" does not appear to occur among the chronic mentally ill residents (Markson and Cumming, 1975). In fact, with regard to psychiatric symptomatology and adjustment, there have been reports of positive changes (DeVries, 1968). In some cases chronic mental patients seem to benefit from relocation from one ward to another (DiScipio & Wolf, 1974). Perhaps, in contrast to normal geriatric groups, relocation is not a particularly stressful event for them. The reason may lie in the fact that many of these patients tend to be socially and environmentally withdrawn either as a result of their illness or of prolonged institutionalization. Some patients may benefit from a move to another ward or building since adjustment to a stable social environment is not necessarily therapeutic for them, particularly if their treatment goal is reintegration into the community.

There is very limited literature concerning relocated mentally retarded residents despite a national trend to transfer them from large institutions to smaller regional and community facilities. Cochran, Sran and Varano (1977) report a "relocation syndrome" in which a few long-term recently relocated adult residents" became profoundly depressed, refused to eat, lost weight, and slept a great deal. One of them died shortly after the onset of her depression. A large number of other individuals of the same age and overall mental functioning

(largely moderately to profoundly retarded) were relocated during the same period without encountering extreme depression. A more systematic study of institutional relocation was conducted by Cohen and his co-workers (1977). They studied two relocated patient populations, Skilled Nursing and Intermediate Care. Residents in the Intermediate Care Program (mean IQ 35) showed a pattern of lowered functioning in language development and withdrawal following transfer. Residents in the Skilled Nursing Program (mean IQ less than 20) by contrast, generally showed increased activity levels of both adaptive and acting-out behavior as compared with their pre-transfer measures. In a six month follow-up of the Intermediate Care group the residents approached the pre-relocation level in language development and amount activity. Six months of program time was lost following the transfer. In research at Pacific State Hospital, Miller found that among 342 profoundly retarded residents who were transferred to a convalescent hospital, mortality was double that of those who remained in the Pacific State Hospital (Rago, 1976). One study (Weinstock, Wulkan, Colon, Coleman, and Goncalves, 1977) found no deleterious effects after relocation. However, in that study, the move was voluntary and was preceded by a counseling and preparatory program.

Explanation of findings

The discrepant findings in the different studies of involuntary relocation can be reconciled if both the personal characteristics of the people transferred and the environmental and process factors of the change are taken into account. Several researchers have found that among the elderly residents relocation has the worst impact on those who are

in the poorest physical health (Marlowe, 1973; Killian, 1970; Goldfarb, Shahinian & Burr, 1972) and suffer from severe brain syndrome. Several studies also found that mortality was higher following relocation among elderly who were psychotic. This finding is not consistent, though, as Aleksandrowicz (1961) and Markson and Cumming (1975) found that mortality of the elderly psychotic was not affected by the move. Aldrich and Mendkoff (1963) found that post-relocation adjustment was better if prior to relocation adjustment was satisfactory, or the residents were angry or demanding. It was the worst if previously the residents were neurotic, depressed, or psychotic. Miller and Lieberman (1965) also noted that people predisposed to depression or neurosis had more severe reactions to the transfer.

The effect of intellectual functioning is not clear. The Cohen et al. (1977) study indicated that severely retarded residents became withdrawn and had decreased language functioning after the move, while the lower functioning profoundly retarded ones increased their behaviors. However, no conclusion can be drawn from this one study. Findings of studies on urban relocation and geographic mobility and theorists on stress however indicate that transfer would be handled better by the higher functioning and better educated residents who have more resources and coping skills.

There is evidence that the way the relocation process is managed may influence the following adjustment. Among the elderly and mentally retarded residents successful relocation programs have provided individualized supportive services, preparatory counseling, and realistic

information about the new setting (Jasnau, 1967; Weinstock et al., 1977). Opportunities to visit the new sites and involvement of the family have also been useful in allaying anxieties. Studies by Novick (1967) with the elderly and Weinstock (1977) with the retarded have shown that participation in decisions about the move and choice in such matters as room assignments can facilitate good adjustment to new facilities. In one study with the mentally ill (DeVries, 1968) resident participation in the move process was not helpful. Residents had input in room assignments and choice of roommates. The author thought that in that case participation led to unrealistic expectations which were not fulfilled later, since normally little participation is allowed in the mental hospitals.

Better adjustment is also reported when the change is less drastic, that is when familiar relationships and belongings are retained (Novick, 1967; Bourestom and Tars, 1974) and people are moved as a group rather than individually. In the book A Nation of Strangers, Packard (1972) notes that during World War II individual morale remained higher when soldiers being sent into strange new situations were sent by units rather than individually. Bourestom and Tars (1974) have shown that maximum change, in which residents and staff in the unit are changed, results in higher mortality than in minimum change moves. The post-relocation adjustment will also depend on the degree of attachment to the old environment. Thus those who have formed close relationships with other residents and staff members will be more affected by the disruption in these relationships.

A critical factor is the quality of the old and new environments.

This is one factor that is often neglected in the research. It seems quite obvious that satisfaction and subsequent adjustment to a move would depend on the "quality of life" in the new environment.

Slover (1972) measured the environmental quality of 26 settings to which a group of elderly mental patients were transferred. The settings were rated by an anthropologist on physical, social and service-related qualities on the basis of a day's observational visit to each. Decline following relocation was greatest in those who had been placed in environments lacking in warmth, individuation, and autonomy. (Marlowe, 1973) used a similar procedure and found that the environmental variables predicted follow-up well-being more powerfully than personal predictors. The degree of autonomy of the individual over his behavior seemed to be the critical factor. Novick (1967) gives an example of a relocation in which the living units were changed so that there would be more privacy and opportunities for group experiences. This resulted in an actual decrease in mortality following relocation. Future research should probably place greater emphasis on the environmental variables than it has done in the past.

Applications

This literature has several implications for the de-institutionalization and relocation of institutionalized populations, which are occurring in the state. The first suggestion is that caution be used in transferring those who are least capable of coping with stress and new situations, such as the nonambulatory, physically unhealthy, and profoundly retarded residents. The other suggestion, which I want to emphasize, is that some thinking go into planning the relocation process so that it facilitates good

adjustment of the residents. This would include use of preparatory counseling, site visits, and family involvement. Also whenever possible, it would be advisable to move units as a whole rather than moving people individually. In that way some of the social networks which have developed can be maintained. If the clients are higher functioning ones, it would also be useful to allow them some choice and participation in the movement process, when possible. The last point is that particular attention should be placed on moving people to new facilities which are environmentally more suitable and which enable a higher quality of life than did the previous ones.

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